1. Covers — med educ.
— research.
— practice.
— prevention.

Brief

THE MEDICAL SERVICES INSURANCE ACT

(Ontario Voluntary Government Plan)

nothing relevant
To Brief 163

! Send To Roy Ellis!

Submitted by:

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CANADIANS ARE RECEIVING POOR ORAL HEALTH CARE

In recent years dentistry has become chiefly a technical replacement service rather than a part of the healing profession. This change has not come on suddenly, but is the result of several factors.

The development of many versatile synthetic materials and high speed equipment (for fashioning dental replacements) has forced dental schools to teach new techniques. Unfortunately, these technical courses have crowded out the biological sciences so important in oral diagnosis and in creating a background for creative inquiry into the causes of oral disease.

Another economic causative factor is the high cost of individual dental practises (which force dentists to find the greatest remuneration for their work). The public has been more ready to pay for material replacement and spectacular surgery than for less radical conservation of oral tissue and preventative dentistry.

The increasing refinement and softening of food is another cause of increased dental debility which has put an increased pressure on dentists to develop better replacement technique.

The undergraduate in dentistry is not taught to recognize and prevent early malfunctions with the result that a great many children at twelve years of age have extensive malocclusions. Parents must either decide to spend a great deal of money (in orthodontic specialists fees) or the child must remain a dental cripple. Functional development of the jaw should be a fundamental concept to be taught to the undergraduate. This is not being done and indicates the control that a few orthodontic specialists hold in the educational system of the undergraduate.

The control of professional dental education by a licencing board is a strange arrangement which I believe has inhibited the development of high calibre dental education in Ontario. Since the licencing board is appointed rather than truly elected by the dental profession, it is often a rather reactionary and ingrown group.

Ontario will never have a good oral health program until dental educational institutions shift their emphasis from developing more efficient dental replacements to encouraging more imaginative dental research.

The image of dentistry as a cosmetic rather than a health survival service has been another deterent in developing good oral health care. This image has been fostered by the dentists' emphasis on replacement service and the strong promotional program of powerful dental cosmetic manufacturers. Biased dental education is provided by manufacturers of cosmetic dentifrices in agreement with short sighted public health bodies while scientific, newer ideas are ignored or not evaluated. The public thinks of dental care as a cosmetic and pain reliever and not as a vital health service. The emphasis on technical treatment has opened the door to cosmetic dentifrice manufacturers to push all kinds of claims for their products without any responsibility for the results. They can take thousands of dollars out of a community and are not held responsible for results of dental conditions in the community.

The expense of dental treatment is another deterrent to a sound oral health program.

Individual competitive practices are costly because:

a. Elaborate equipment - (soon obsolete)
b. Dependance on outside — technical assistants who are independent of the dental profession.
c. Bulky design of equipment precludes any chairside assistance for the dentist.
d. Dentists have <u>not</u> been trained to use qualified clinical personnel.
e. Technical personnal have <u>not</u> been trained to work in medical service situations and to understand practice relationships.
f. There are not enough dentists and those that exist are unable to meet the needs of the public with the present system of practice.

This lack of personnel for dental health clinics has been a cause of poor oral health care. Much acute treatment could be handled by dental internes in decentralized clinics associated with hospitals or district health units. Unfortunately, under the present system, the only dental clinic of this type is a massive $3,500,000 clinic at the University of Toronto. The Ontario taxpayers are not receiving the benefits that they should from this single clinic. Decentralized clinics would give wider experience to interning dentists and increased dental care to more Ontario residents.

During the last twenty years, there has been little or no concerted effort by the Faculty of Dentistry, University of Toronto, to investigate the causes of oral diseases, to search for control of periodontal infections or to relieve the increased tragedy of malocclusions which is prominent in 80% of children today. Technical teaching alone cannot provide an answer to oral health problems.

The University of Toronto, Faculty of Dentistry had a marvelous reputation for creative research into the causes of dental diseases while Dr. H. K. Box was in charge of the research program. If, after Dr. Box's death, the Research Department had continued to pursue problems that Dr. Box had initiated instead of following less imaginative approaches of other dental schools, Toronto would have undoubtedly by now solved many of the problems of oral infection.

In my practise over the past sixteen years I have been carrying out principles advocated by Dr. Box and furthering them through clinical studies. Clinical evidence has consistently verified his work. I believe that oral diseases are caused by specific infections and research should be directed to the following purposes:

1. That a specific microbe is the essential cause of an infectious disease and that other contributory factors necessary for its clinical expression are secondary or prominent causes.

2. That oral diseases result from infectious microorganisms and parasitism which may affect seriously other parts of the body. The mouth is the portal for entrance of infection into the body.

3. That mechanical treatment of the tooth, including its removal, does not necessarily limit an infectious process.

4. That people may retain oral septic conditions for years, even after having had restorative or surgical treatment. This may affect their health seriously, and may lead to a variety of systemic diseased states. It is obvious that there is a need for the development and study of medications that will lead to the eradication of septic foci as rapidly as possible.

5. That further study or plural studies must be undertaken with proper microscopic and cultural techniques to overcome the difficulties and errors previously encountered.

6. That additional research funds being made available, studies of specific identifications would prove the presence of such microbial invasive organisms. Clinical testing would be best undertaken by Oral Medical Departments, preferably associated with a Medical School.

7. After these organisms have been identified and studied, such agents as cheomotherapeutics, antibiotics, vaccines, et cetera could be tested and used against them with the hope of eradicating them from the body.

I disagree strongly with the dental schools' teaching that the removal of a tooth eliminates infection in a mouth, and the placement of artificial dentures over these diseased tissues eliminates oral sepsis from the mouth. It is based upon false premises because:

a. The tooth is only a product of the oral tissues. It is produced by the invagination into the oral tissues of the tooth germ and reappears as a product only of these same tissues. Therefore, the removal of the tooth does not necessarily clear up the infection in the mouth any more than the removal of a fingernail necessarily clears up the infection in a hand. There is an ever increasing evidence that infection is in the living tissues of the mouth and mechanical treatment alone cannot correct it.

b. There is a great deal of evidence that a cavity, or a hole in the tooth, is only one sign of oral disease and its repair does not correct the oral infections in the mouth. Thus, although teeth may be "filled", the infection continues in the child's or adult's mouth and can do damage to the whole body.

c. It is evident that a technical treatment of a tooth or teeth does not eliminate the oral infection in the mouth because of the repetitive nature of the work. This is evidenced by the eventual loss of teeth by the individual.

I disagree strongly with the lack of professional discipline and protection that is afforded the public in regard to dental services. Under the present practice of dentistry, extractions, surgery and all types of oral treatment come under the surveillance only of the individual dentist because there is no overall control of the principals of treatment. This has been corrected and controlled in medicine by hospital boards and provincial hospital rating bodies. Dental patients are subjected too often to hasty decisions in individual dental offices which may do untold harm to their future health. Supervision under accredited hospital boards would prevent indiscriminate removal of teeth and provide for a medical treatment of oral diseases.

Possible Solutions:

1. Licenses should not be handled by the authority that handles academic training and thus there should be a separation of the academic training and research from the licence to practise.

2. Recommendations from the Gies Report (1926)* and by the Survey of Dentistry (1961)+ should be reevaluated and implimented such as:
   a. A liberal arts education
   b. A liberal arts in fundamental biological sciences
   c. An indenturship in oral medical hospital services after academic training in basic sciences and humanities.

3. Clinical technical equipment should not be a part of a university. It should be located in out-patients departments in hospitals and in accessible oral health clinics throughout the province thus giving service to taxpayers who pay for it. The present location of the only dental school in Ontario has tended to produce young graduates dependant on technical training. An academic atmosphere of basic sciences would be more apt to stimulate creative research into the causes and prevention of oral diseases. Technical training should be received through internship under skilled professional men, as in medicine, providing oral health services to the public.

4. Universities must be responsible for research directed at the causes of oral diseases and the effectiveness of therapies for the healing and preservation of oral tissues. This is not the present policy.

*Gies Report — Carnegie Foundation 1926

+Survey of Dentistry (1961) — American Council of Education,
1785 Massachusetts Avenue, N.W.,
Washington, D.C., U.S.A.

Imperatives of an Oral Health Service:

1. Oral health services must safeguard the quality of dental practices and preserve the essential personal relations between patient and dentist.
2. Oral health services must be designed to encourage the patient and families to retain their oral structures and to maintain them in good health. The main provision of the services should be the incentive to keep people healthy rather than seek replacements for carelessness. Very few plans are remunerative to the family who tries to remain healthy and to help themselves.
3. There should be full application of research and knowledge into the prevention of oral diseases, and all dental practise should be permeated with prevention and control of oral diseases rather than mechanical replacement as the dental service.
4. Treatment must be concerned with discovering the relationship of oral foci manifestations to systemic diseases and disorders. More understanding must be given to biological and pathological conditions, and less to the mechanical actions and reactions of replacements that may be more harmful than helpful to the health of the mouth.
5. Oral health services must work towards a medical approach to control of oral diseases, and must be capable of change and correction in the light of new knowledge from research. The technical services of appliances and replacements must be a subsidary service rather than a main oral health feature. This is best supplied by ancillary assistance working in conjunction with oral health diagnostic and professional services.

Recommendations for Improvement in Dental Education:

1. Academic training should be a basic discipline of the University and associated with academic training in other basic sciences.
2. The candidates should have at least two pre-professional years of college study. He should take preferably three years of undergraduate curriculum covering intensive basic biological training in medical science, clinical studies and dental technology, with additional one or two years of internship in oral medical departments in hospitals.
3. Oral specialist should be required to take a full year or more in graduate curriculum in addition to the three years of undergraduate curriculum and the internship.
4. Technical training should be carried out in oral medical departments in hospitals under trained professional men, where the sharing of knowledge with other scientific men could do much to improve the oral health services of Canadians.
5. Universities must be responsible for research direction at the causes of oral diseases and the effectiveness of therapies for the healing and preservation of the oral tissues. This would stimulate academic training through scientific research and biological studies.
6. Oral Health Services should be a vital part of the Medicare Program for the Province of Ontario if it is used as a medical approach to the problems of oral diseases.

Possibilities of Oral Health Services to the citizens of Ontario could be:

1. Non compulsory (they would understand the benefit of it)
2. Operated through private agencies
3. Available to all
4. Payment made quarterly

Possibilities of Oral Health Services to the citizens of Ontario could be (CONTINUED):

5. Insured under scientific principals rather than cosmetic treatment.
6. Doctor - patient relationship retained
7. A basic service of the general practicioner in dentistry with a family plan of Medical Insurance Services
8. An encouragement for children and adults to value healthy mouths and provide an incentive to keep them healthy.

CONCLUSION:

Fulfilling the recommendations in this brief would provide Oral Health Services to all people in Ontario. It would provide for the preservation of oral structures rather than the costly provisions of replacements and provide control for oral diseases. Ultimately, there is the greatest possibility that a child could go through life free of oral diseases through the development of a vaccine or other scientific protective mechanism. This protection would be comparable to that of diptheria toxoids, small pox vaccines, et cetera achieved in medicine today.

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124 EDWARD ST.
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December 19, 1963

Dean J.D. Hamilton
Faculty of Medicine
University of Toronto

Dear John:

Thank you for letting me see the briefs submitted by Charles T. Peterson. In reading these briefs, I am sure you learned that this gentleman has little time for the Faculty of Dentistry of this University or its staff. Our one great regret is that we ever admitted him to postgraduate study a few years ago.

Some time when you have nothing else to do, it might be enlightening to gather opinions on this gentleman from some of his colleagues in London, Ontario where he practices. He is an absolute menace to the profession.

Yours sincerely,

R. Roy
Dean

RGE:hc
enc.